July 7, 2014

Providerfirstname/LastName
«address1»
«address2»
«City», «State» «zip»

Dear Provider:

One of your patients is participating in our research study and has granted permission to our study to view her medical records. Enclosed you will find a signed release of health information form. Please provide a copy of all the documents in the patient's medical record regarding the fertility treatment for her latest pregnancy between the dates of <**insert time window from interview data**>. If possible, please provide the documents on an encrypted compact disk (CD). If this is not your patient, please let us know at <**Insert local CBDRP phone contact>**.

Please mail the requested medical records or CD to the following address:
<**Insert local CBDRP address**>

If mailing records, please mark envelope as CONFIDENTIAL.

Alternatively, you may fax them to <local fax number>.

Some providers do not charge for medical records requested for research purposes. If this is not the policy of your group and you plan to charge for providing these records for research, please contact me at <**Insert local CBDRP phone contact>** prior to sending the medical records.

You may not bill the patient for this medical record request.

If you have any questions or need additional information, please do not hesitate to contact me. We appreciate your timely response to this request.

Sincerely yours,

<Insert Local PI Name and Address>